Brant Community Healthcare System
The Willett, Paris
The Brantford General

GENERAL CONSENT FORM

1. CONSENT FOR MEDICAL TREATMENT

I, _____
(Name of Patient or Substitute Decision Maker) hereby CONSENT to undergo the treatment/procedure/operation of

_____

to be performed on _____(me/patient's legal name)

proposed by _____(Name of Health Practitioner), to be performed by

_____ (Name of Health Practitioners or his/her delegate).

_____ (Name of Health Practitioner) has explained to me the nature of the treatment/procedure/operation, the expected benefits of the treatment/procedure/operation, the risks of the treatment/procedure/operation, the side effects of the treatment/procedure/operation and the alternative courses of action including the likely consequences of not having the treatment/procedure/operation. I have had the opportunity to ask questions about the treatment/procedure/operation and have had my questions answered to my satisfaction.

I also consent to such additional or alternative procedures as may be necessary or medically advisable during the course of such treatment/procedure/operation.

DATED this _____ day of _____, 20____

_____ _____
SIGNATURE OF PATIENT (OR SUBSTITUTE DECISION MAKER, IF APPLICABLE) LEGAL NAME (Please print)

I have explained to _____ (patient) the nature of the treatment/procedure/operation, the expected benefits of the treatment/procedure/operation, the risks of the treatment/procedure/operation, the side effects of the treatment/procedure/operation and the alternative courses of action including the likely consequences of not having the treatment/procedure/operation. To the best of my knowledge _____ is giving their informed consent to the treatment/ procedure/ operation voluntarily.
DATED this _____ day of _____, 20____

_____ _____
SIGNATURE OF HEALTH PRACTITIONER RECOMMENDING TREATMENT LEGAL NAME (Please print)

2. CONSENT TO BLOOD TRANSFUSION

_____ (Name of Health Practitioner) has explained to me the nature of a blood transfusion(s) and/or the administration of blood products, the expected benefits of the transfusion(s) and/or the administration of blood products, the material risks of the transfusion(s) and/or the administration of blood products, the material side effects of the transfusion(s) and/or the administration of blood products.

☐ I understand the explanation and am satisfied that my questions have been answered. I hereby **CONSENT** to the transfusion(s) and/or the administration of blood products.

☐ I understand the explanation and am satisfied that my question have been answered. I hereby **REFUSE CONSENT** to the transfusion(s) and/or the administration of blood products.

DATED this _____ day of _____ 20____

_____ _____
SIGNATURE OF PATIENT (OR SUBSTITUTE DECISION MAKER, IF APPLICABLE) LEGAL NAME (Please Print)

I have explained to _____ (patient) the nature of the treatment/procedure/operation, the expected benefits of the treatment/procedure/operation, the risks of the treatment/procedure/operation, the side effects of the treatment/procedure/operation and the alternative courses of action including the likely consequences of not having the treatment/procedure/operation. To the best of my knowledge _____ is giving their informed consent to the treatment/ procedure/ operation voluntarily.
DATED this _____ day of _____, 20____

_____ _____
SIGNATURE OF HEALTH PRACTITIONER RECOMMENDING TREATMENT LEGAL NAME (Please Print)

Brant Community Healthcare System
The Willett, Paris
The Brantford General

GENERAL CONSENT FORM

3. CONSENT FOR CHOICE OF ROOM AND ADDITIONAL EXPENSES

ACCOMMODATION REQUESTED: WARD ☐ SEMI-PRIVATE ☐ PRIVATE ☐

For services rendered to the above named patient, I agree to pay the Brant Community Healthcare System any balance not covered by O.H.I.P. or any other agency. This balance to be paid within 30 days of receipt of invoice, unless other arrangements have been made in writing.

I hereby consent to the release of any relevant information to the Workplace Safety Insurance Board or other appropriate insurance companies.

_____ _____
SIGNATURE OF PATIENT (OR OTHER) RELATIONSHIP TO PATIENT (IF OTHER)

_____ _____
WITNESS DATE AND TIME

4. RELEASE OF RESPONSIBILITY FOR PATIENT POSSESSIONS

While in hospital, all patients are urged to send home all valuables and items not needed while hospitalized. Any valuable not left at or sent home may be deposited in the hospital vault. Your nurse can assist you with this. The hospital assumes no responsibility for patient's possessions, with the exception of any valuables deposited in the hospital vault, as noted above.

I accept full responsibility for all possessions I have brought to the hospital.

_____ _____
SIGNATURE OF PATIENT (OR OTHER) RELATIONSHIP TO PATIENT (IF OTHER)

_____ _____
WITNESS DATE AND TIME

5. WAIVER-REFUSAL OF MEDICAL TREATMENT

_____ (Name of Health Practitioner) has explained to me the nature of the treatment/procedure/operation of_____
expected benefits of the treatment/procedure/operation, the material risks of the treatment/procedure/operation, the material side effects of the treatment/procedure/operation and the alternative courses of action including the likely consequences of not having the treatment/procedure/operation.

I _____
(Name of Patient) understand the explanation and am satisfied that my questions have been answered.

I hereby **REFUSE CONSENT** to the _____ treatment/procedure/operation.

I hereby release Dr. _____ and the Brant Community Healthcare System from any ill effects, injuries or damages, including death which might result from my refusing this treatment/procedure/operation.

I understand the explanation and am satisfied that my questions have been answered.

DATED this _____ day of _____ 20____.

_____ _____
SIGNATURE OF PATIENT (OR SUBSTITUTE DECISION MAKER, IF APPLICABLE) LEGAL NAME OF PATIENT (OR SUBSTITUTE DECISION MAKER, IF APPLICABLE)